problems of common interest can be very profitably discussed. In some county medical societies of the State, as a matter of fact, this has been the standard custom for some years, and there is abundant testimony that much good has resulted therefrom. If your own organization has not done so, why not urge the officers and program committee to consider the possibility of similar meetings?

POSTGRADUATE CONFERENCES DURING FALL AND WINTER MONTHS

Attention of County Society Postgraduate Committees Requested.—Most of the County Societies have appointed Postgraduate Committees upon which falls the responsibility of making surveys of local postgraduate needs and facilities, and of supervising the arrangements for guest and local lecturers and demonstrators. Where local postgraduate committees do not exist, the county society officers may act as the committee. Such committee members may wish to utilize the opportunities existing, during the vacation months, to develop plans for clinical conferences to be held in the coming fall or winter, with special reference to probable dates and places of the meetings, and geographical territory to be included in the conference effort, and to select major topics seemingly most desirable for presentation, as well as the guest speakers whose presence is desired. Tentative decision on whether a one or two-day clinical conference would be the more desirable, with best days of the week or month for the gatherings, as well as estimates of expenses in necessary publicity and transportation costs, are other items of importance to be debated.

* * *

State Association Committee on Postgraduate Activities. — The Committee on Postgraduate Activities of the California Medical Association, acting through the Central Office in San Francisco, will welcome early communications from all who are interested. A roster of members who have signified their willingness to participate in the proposed clinical conferences is available, and names of guest speakers will be gladly sent for consideration.

Of importance, also, are such matters as the transportation and hotel expense of guest speakers. Speaker colleagues, who give time and effort in these activities, have already, by so doing, indicated their willingness to bear a generous part in the postgraduate work; but they should not be called on, in addition, to donate their traveling and hotel expenses. It is only right that the audience participants should bear their proportion of the conference costs, especially since this item can usually be covered through a modest registration fee, designed to defray expense of sending out notices, engaging meeting halls, and providing for transportation and hotel service. The State Association Committee on Postgraduate Activities is permitted to aid financially in only a limited extent. Conference Committees are reminded that travel expenses are in proportion to distances covered, on which account it may be desirable to consider guest speakers from centers not too far away.

As before stated, correspondence is invited and should be addressed to the Association Secretary, who, through by-law provision, is also secretary of the California Medical Association Committee on Postgraduate Activities.

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH AND ITS DEFICIENCIES (?): AS INTERPRETED BY PROFESSOR PENROSE

Assembly Bill 2107.—The story of Assembly Bill 2107, introduced at Sacramento on January 25, 1939, and designed to legislate into being a new set-up for the State Board of Health, was outlined in the opening editorial of the July issue of CALIFORNIA AND WESTERN MEDICINE.*

* * *

California Medical Economic Survey.—The edition of the "California Medical Economic Survey," brought off the press in 1937, and a copy of which was then sent to each member of the California Medical Association, contained only the factual data of the survey, as embodied in 143 tables, 57 charts and 14 pages of form blanks, with the addition of a limited amount of informative text.

* * *

A Later Volume.—More recently and during the current year, another volume dealing with the survey has been issued, in which original and revised text appear, the financial sponsorship for its production being presumably indicated in a preface with the following words:

> The California Osteopathic Association, largely through the loyal efforts of its legislative director, Dr. Glenn P. Caylor, has been responsible for keeping the study alive by means of last-minute emergency financial appropriations, and by this aid, extended at a time when it was so badly needed, publication of the complete and uncensored findings has actually been effected. The Russell Sage Foundation of New York has also been very helpful in this emergency.

Part IV of the volume is entitled, "The Organization of Medical Services," with chapters: "The Public Health Situation in California," on page 283; "Nature and Extent of Public Health Activities," on page 306; "Health Insurance," on pages 353-405. Concerning the authorship of this portion of the book, in which considerable revision from the original text of 1937 has been made, the preface states:

> The authors [Dodd and Penrose] have divided the work between themselves, Professor Dodd being responsible for the final manuscript of Parts I, II, III, and V, and Professor Penrose of Part IV. . . .

* In the comments in the July issue, reference was made to the " 'Bureau of Public Administration of the University of California,' with which Professors May and Penrose are affiliated." We had been misinformed in regard to the above. Professor Penrose has no connection with the Bureau of Public Health Administration, although he did speak on Assembly Bill 2107, in the Committee hearing at Sacramento. Professor May is Director of the Bureau of Public Health Administration and spoke to lay audiences on health insurance, but did not appear in connection with the State Board of Public Health Bill (A. B. 2107). We express regret at our error in statement.—Editor.

Purpose of the Present Comments.—In our present comments, in one sense, supplementary to the discussion of A.B. 2107, on pages 1-4 in last month's issue of CALIFORNIA AND WESTERN MEDICINE, we desire to discuss somewhat only the fourteen "conclusions" given on page 303, at the end of the chapter, "The Public Health Situation in California." Since the writer was for some years a member of the State Board of Health, and is, therefore, somewhat familiar with its history and record of achievement, it may be in order briefly to call the attention of members of the medical profession to astonishing statements which Professor E. F. Penrose has made in his so-called "Conclusions." These fourteen summings up by Professor Penrose and our comment follow:

*Conclusion 1.—In 1870 California, along with Massachusetts, occupied a position of leadership in public health organization in the United States; but as regards state activities in public health, it has for a long time lost all claim to leadership.**

Comment.—The public health record of California does not indicate any loss in leadership. In spite of handicaps established by the presence of large groups of unassimilable foreign-born, including a large Mexican population, the migration to California of hosts of health-seekers and agricultural laborers from other states, the necessary use of surface streams, largely, for public water supplies, the State's proximity to Oriental countries, the presence of inordinate numbers of health cultists, and other detrimental factors not encountered in other states, the public health record of California is far better than that of the majority of the states. In fact, it compares favorably with that of states that expend far larger sums of money for public health services and which do not encounter the obstacles found in California.

* * *

Conclusion 2.—This loss of leadership seems to have been due partly to the retention of an antiquated form of organization of the State Department of Public Health, under which activities are controlled by a board of seven persons, the majority of whom have had no previous experience of public health activities, and whose experience and interests are primarily centered on private medical practice.

Comment.—The contention that there is a loss of leadership in California, due to the form of organization of the State Department of Public Health, would also apply to at least twenty-nine other states which have similar organizations.

These include Indiana, Minnesota, New Jersey, Wisconsin, and Maryland, all of which are acknowledged as having outstanding state public health organizations which achieve excellent records in public health service.

* * *

Conclusion 3.—The office of State Director of Public Health in California in no way corresponds to the office of health commissioner in the states in which public health organization has made the best development. Administrative and executive functions are vested in the whole Board of seven members and not in the Director alone, with the result that the Director is not in a position to direct. The law fails to specify that direct qualifications in public health administration shall be required of the members of the Board or even the Director. An able and energetic Director would be hampered by the necessity of carrying with him a board likely to be reluctant to permit any supposed encroachment of public health activities on what is regarded by medical practitioners as a field reserved to private practice.

Comment.—In California the State Board of Public Health was organized entirely upon the initiative of the medical profession. For almost three-quarters of a century the responsibility for the maintenance of public health in California has been placed upon a Board composed of doctors of medicine. The executive officer has always been a member of the Board, and the fact that serious emergencies, such as outbreaks of bubonic plague,* epidemic poliomyelitis and many other acute infectious diseases, have been terminated through control exercised by the Board, indicates that this form of organization is efficient and achieves results of lasting benefit to the public health of the State.

* * *

Conclusion 4.—The maximum insecurity of tenure is attached to the office of State Director of Public Health, who can be dismissed "at the pleasure of the Governor." In all states with well organized state health departments, the commissioner of health is guaranteed at least four years in office. The present law in California leaves an opening for grave abuses.

Comment.—The fact that the public health authority rests in the California State Board makes it important that the executive officer be an individual who may deliberate with other members and who may always represent the opinion of the Board. The tenure of office is important, but willingness to take part in deliberations, to abide by the majority opinion, and to successfully enforce the rules, regulations, and orders of the Board are of first importance, and lead to long tenure of office, as proved by experience.

* * *

Conclusion 5.—In the states recognized by public health experts as having the best organized state departments of health, all executive and administrative powers are placed in the hands of a state commissioner of health, and a public health council exists, the functions of which are advisory and not concerned with executive matters. State health commissioners and members of advisory councils are required to have had qualifications and experience in public health administration and sanitary science, nor are advisory councils composed solely of private medical practitioners. This form of organization, found in New York, Massachusetts, Pennsylvania, Michigan, and Ohio, is demonstrably superior to the old-fashioned form retained in California.

Comment.—The California State Board of Public Health has never failed to rely upon the opinions of expert consultants in all fields of public health. Its consultants are of outstanding ability.

Members of any higher judicial court are not required to have special training in corporation, crime, or other legal specialties: their general training and mature judgment enable them to provide a judicial service and to render opinions in accordance with American principles of justice to all.

Similarly, members of the California State Board of Public Health are not required to have had special training in any single branch of medicine. Their training and experience as practicing physicians enable them to formulate policies that are successful in accomplishing recognized achievements in the prevention and control of disease.

* The California State Board of Health came into existence in 1870, largely through the efforts of the medical profession, under the inspiring leadership of Dr. Thomas M. Logan, a South Carolinian who settled in Sacramento in August of 1850. In that same year, Doctor Logan, with Dr. E. S. Cooper of San Francisco, issued the call for the organization of a State Medical Society, and in 1870 he was instrumental in its reorganization. Doctor Logan was then president of the Medical Society of the State of California in 1870, and at the same time he was also secretary of the newly organized California State Board of Health. It is evident, therefore, that the initial public health efforts in California were, from the beginning, interwoven with those of organized and scientific medicine.

* An illuminating example of the independence and courage of the medical profession of California, in opposition to the political forces of the State, may be found in the articles by George H. Evans on "Plague Epidemics in California" in the following issues of CALIFORNIA AND WESTERN MEDICINE: November, 1938, on page 383; December, 1938, on page 458; January, 1939, on page 24.

Conclusion 6.—The tenure of local public health officers in California, both in counties and incorporated cities and towns, is, from the standpoint of State laws, deplorably insecure. The State Director of Public Health can do nothing to prevent the dismissal of a well qualified local health officer for political reasons.

Comment.—Since the days of the New England town meeting, the policy of establishing local government within local communities has constituted the very essence of civil government in the United States.

Laws for state control over undesirable health conditions in local communities for use in emergencies are sufficient and insure the maintenance of the public's health.

The suggestion that a state health organization should exercise privileges of patronage in local communities is un-American and indicates a lack of sympathy with our existing form of government.* It would be as logical for the proponents of this suggestion to propose that the Federal Government take over the control of the government of the states.

* * *

Conclusion 7.—The qualifications required of local health officers under existing laws are wholly inadequate. There is no legal assurance whatever that persons appointed as local health officers will necessarily possess sufficient experience and qualifications, and the State Director of Public Health has no power to prevent the appointment of inadequately qualified persons.

Comment.—This conclusion is unfair to the twenty-five counties that have organized, full-time public health units, with qualified health officers serving such units. In those counties where sparse populations and lack of funds make the organization of full-time health districts impossible, the State has always provided public health services, pending such time as adequate control measures are available in these communities.

* * *

Conclusion 8.—A considerable proportion of the people of California are living in areas in which there are no full-time public health officers and wholly inadequate health protection is given.

Comment.—It is a fact that almost 95 per cent of the population of California enjoy the benefits that come through residence in communities where full-time public health service is provided. The conclusion is, therefore, untrue.

The remaining 15 per cent receive nominal public health service from the State, and, in many instances, special services are provided as indicated.

* * *

Conclusion 9.—Some of these areas are financially in a position to maintain full-time public health service, but public inertia must be overcome by persuasion or pressure from within and without before changes can be made.

Comment.—The State provides every possible facility for encouraging the formation of full-time public health units. Within the past two years, no less than seven such units have been organized through the efforts of the State Board of Public Health. The statement is unfair in its contention that no attempt is made to encourage the development of efficient local health service. A special bureau of county health work, for example, is active in providing prematernal services.

* * *

Conclusion 10.—Other counties are likely to remain for an indefinite period financially unable to maintain full-time public health services. Hence it would be impracticable to pass legislation compelling all counties to establish full-time public health services without making other adjustments.

Comment.—The State provides at least nominal public health services in those communities that are financially unable to maintain full-time public health service. Far better results can be achieved through education in public health than through the attempted exercise of compulsion, where such enforcement is impossible.

* * *

Conclusion 11.—Some counties and incorporated towns form suitable units for the maintenance of public health departments, but others do not. It is desirable that in the latter local health districts be formed which in some cases will cross county lines.

Comment.—For almost two decades there have been laws upon the statutes of California that would enable a local health district to cross county lines. Until recently, however, there has been only one local health district organized in California, and that has confined its limits to a single county. No California county as yet has consented to relinquish its rights as a government unit. Until such time as the whole structure of government may be changed, this attitude would, no doubt, prevail.

* * *

Conclusion 12.—The Local Health Districts Act of 1917 makes possible the formation of local health districts which may, if necessary, cross county lines. Up to now only one local health district, that of San Joaquin County, has been formed. This district does not cross county lines, but combines county and incorporated city territory. Competent public health experts agree that San Joaquin County has one of the best county health departments in the United States. The Local Health Districts Act, however, is a permissive act, and local political difficulties would have to be overcome before advantage could be taken in many districts of the opportunities which it affords.

Comment.—The organization of the San Joaquin Health District was effected through the united efforts of the local medical profession, service clubs, commercial organizations and influential residents of that county. The plan of organization is distinctive in that funds for support of the district are derived through a tax levy rather than appropriations made by the board of supervisors. Nevertheless, the district submits an annual budget for approval of the supervisors, and the funds are spent and the tax levied only in conformance with the actual needs of the district. Any county in the State may take advantage of the provisions of the Local Health Districts Act. Many of the full-time county health units in the State now have organizations that are identical with that of the San Joaquin Health District, with the exception of the fact that funds are derived through appropriations rather than tax levies. Since many of such units are subsidized through the provision of Federal and other funds, the application of the Local Health Districts Act is less advantageous than their present method of financing.

* * *

Conclusion 13.—Six State health districts were formed in California in 1917 and a number of State district health officers were appointed after a strict civil service examination open to the candidates throughout the country. The officers appointed rendered valuable services, but, due in part to the War and in part to a less progressive attitude on the part of later State Boards of Public Health, the scheme gradually collapsed, without the adoption of satisfactory alternative methods of achieving the objectives which the State health districts were designed to achieve.

Comment.—The State health district plan established in 1917 was dissolved, not through any action or attitude on the part of the State Board of Public Health, but rather through the action of the Legislature, which refused to appropriate funds for the continuation of such districts. In many states where similar districts have been formed, the plan has been abandoned as unfeasible. This is notably true in Illinois and Ohio.

* * *

Conclusion 14.—The personnel and the resources of the State Department of Public Health are wholly inadequate to render needed assistance to local health departments, and to stimulate local interest in the formation of full-time departments of public health. Alternative remedies may be found in the revival of State health districts or the strengthening of the State Department of Public Health by larger appropriations and additional civil service personnel. But

* Without desire to introduce personalities, it may be of interest to note that Professor E. F. Penrose secured his American citizenship papers on February 19, 1937.

the effectiveness of either of these remedies depends on the concentration of all executive and administrative powers in the hands of a competent and vigorous State Director of Public Health.

Comment.—The California State Board of Public Health maintains a Bureau of County Health Work that devotes its whole efforts to the organization of full-time county health units, and with marked success. The plan of State district health organization has been demonstrated as impractical, not only in California, but in other states as well. Until such time as the county is abolished as a local unit of government, public health legislation must conform to existing legal standards. Whenever the counties may consent to consolidation into units, composed of groups of counties. public health laws will naturally conform to the general legal structure that consolidation would bring.

It is believed that the present personnel and present appropriations allotted to the State Board of Public Health enable full service to the public and without placing undue burdens upon taxpayers. The present director of the State Department of Public Health has served efficiently under five administrations of State government, and, since 1920, when he assumed office, most outstanding records in communicable disease control and promotion of public health have been achieved. To question the competence and efficiency of the California State Board of Public Health and the Director of the Department indicates gross ignorance of the public health record of California.

* * *

Final Comment. — With due deference to whatever profound knowledge the authors of the book here discussed may possess along academic lines, it is our belief that more study might have advantageously been given by them, before venturing to such interpretations, with the positive commitments included in the fourteen "conclusions" here commented upon.

A. M. A. WINS AT WASHINGTON, D. C.

Press Clippings Tell the Story.—Press dispatches dated July 26, Washington, D. C., at a time when this August issue of CALIFORNIA AND WESTERN MEDICINE is in press, bring the happy tidings that efforts of the United States Departmen of Justice, under the leadership of Assistant Attorney General Thurman Arnold, to invoke the Sherman anti-trust law of the year 1891 against the American Medical Association have come to naught, through a ruling handed down by Justice James M. Proctor of the District of Columbia Federal Court.*

For further details, see under "Press Clippings," on page 130 of this issue.

California Medical Association members who failed to note the press dispatches referred to, should take the time to read this important news.

Other State Association and Component County Society News.—Additional news concerning the activities and work of the California Medical Association and its component county medical societies is printed in this issue, commencing on page 116.

* On July 31, the U. S. Department of Justice asked the United States Court of Appeals to overrule the lower court decision.

EDITORIAL COMMENT†

WEATHER AND MEDICINE

The supposition that environmental factors influence the living organism is not new: no less a person than Hippocrates discussed it. Recognition of these influences has increased with the emergence of medicine from the early chaos of speculation and ignorance. The interwoven research of physicists, meteorologists, mathematicians and medical men has laid the foundation of a new branch of medical science: "Meteorobiology." The mysticism of the ancients has been eliminated, while speculation has been placed upon such a mathematical basis that it may almost be said to pertain to the realm of proved fact.

Introduced by the Norwegian school of meteorologists, a common interpretation for meteorological phenomena obviates the earlier contradictory results of various researchers. Previously, each author based his observations upon some different, uncorrelated factor such as temperature, barometric pressure or humidity; now, Bjerknes' "Front"-theory has been generally adopted. In this theory each factor is demonstrated as part of a whole syndrome, and it is this syndrome of events, occurring in forward or reverse order, which influences the living organism. Popularly, this is called "change of weather."

The most important cause of weather change is the passage of the so-called "discontinuity surface" which separates air masses of opposite physical characteristics traveling in opposite directions. The two main types of air masses are the polar, originating over the polar and subpolar regions, and the tropical, originating over the subtropical zone. These intermix to no appreciable degree, so the discontinuity surfaces are generally zones of rapid transition termed "fronts." The cold front lies between the tropical current and the advancing polar air mass; it is marked by a sharp drop in temperature, decrease in humidity and a steady rise in barometric pressure. The warm front lies between the receding cold air and the tropical current: it is marked by rise in temperature and humidity and a falling barometric pressure.

Petersen[1] in this country and De Rudder[2] in Germany have demonstrated that passage of the above fronts exerts a very definite influence upon certain diseases (and symptoms) both as to onset and course. Proved statistically is the correlation between changing fronts and the following: Laryngeal croup, spasmophilia, eclampsia gravidarum, rheumatic pains, neuritic pains (tabes), lobar pneumonia, acute upper respiratory infections, hemoptysis, apoplexy, diphtheria, acute glaucoma. A highly probable correlation exists between weather

1 Petersen, W. F.: The Patient and the Weather, Edwards Brothers, Ann Arbor, 1935–1938.

2 De Rudder, B.: Grundriss einer Meteorobiologie des Menschen, Springer, Berlin, 1938.

† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.